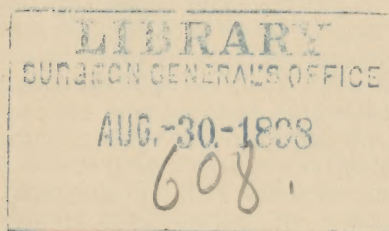


Hopkins (S.D.)

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A Case of Hysteria Simulating Organic Disease
of the Brain.



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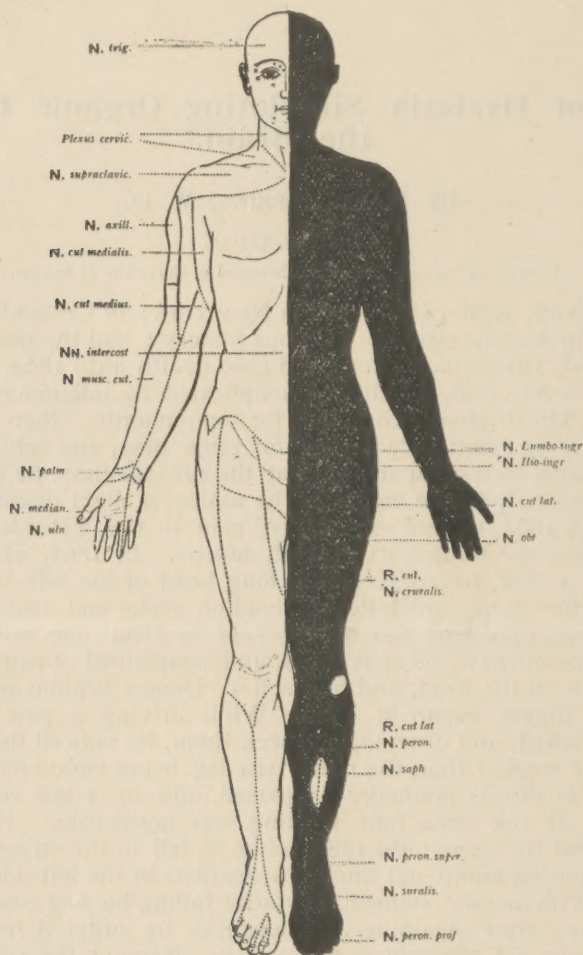
Lecturer on Nervous and Mental Diseases in University of Denver.

T. G., aged 67, stone-cutter, born in New York; in Colorado three years. Family history negative. Previous history: had the usual diseases of childhood, after which he enjoyed good health until 1862, when he suffered from a severe cold, which was complicated by inflammation of the left middle ear. The discharge continued for some months; then became intermittent, occurring about once a week for some time, and subsequently, the intervals became further apart, and, at the present time, he does not have any discharge—only in the mornings, he notices a slight discoloration of the pillow. Since 1864, he has experienced pain in the left side of the chest, cough, and he expectorates a yellowish mucus. In 1865, while pulling on the stump of a tree, he ruptured the long head of the left biceps tendon. The piece of the stump which he had hold of, broke and struck him on the head and chest, rendering him unconscious for about one-half hour. After regaining consciousness, he spat blood, and complained of pain in the chest, a roaring noise in the head, and headache. Denies syphilis and alcoholism.

Present illness began in 1866. While driving a pair of colts, they became frightened, and in trying to check them, he noticed that the left leg and arm were weaker than the right; the leg being more effected than the arm. The weakness gradually increased, and in a few months, it was marked, and at the same time wasting was noticeable. His symptoms remained about the same until 1880, when he fell in the street. Before the fall he experienced numb and tingling sensations in the left side of the body, headache and dizziness. Immediately after falling he lost consciousness for one-half hour; after regaining consciousness he suffered from the same symptoms as he did previous to the attack. None of the symptoms were exaggerated after this spell. In the succeeding two years he had four attacks, similar in all respects to the first one. After each he suffered from dizziness and headache. He was free from the attacks from 1882 until two years ago, 1895 (during this interval the paralytic symptoms remained stationary), when they recurred, but increased in frequency, having an unconscious spell every third month.

I am unable to get a definite history about the attacks of unconsciousness from the patient or son, as the latter has never seen him in one of these spells, and the statements of the patient are unreliable, as he changes

the duration of the attack from day to day. In one attack he claimed to have bitten his tongue, but on examination of the mouth, I am unable to detect any scars.

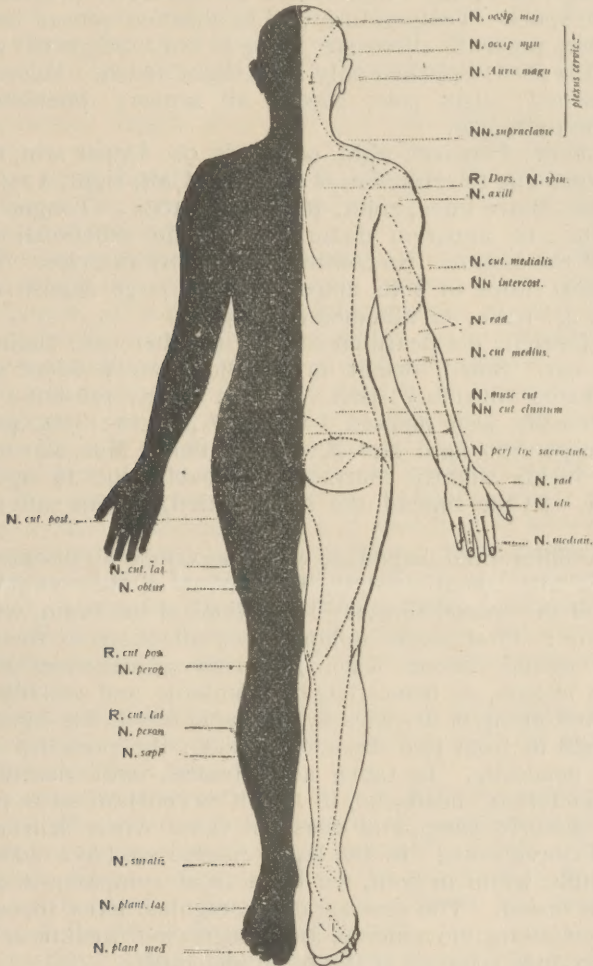


SHOWING DISTURBANCE IN SENSORY PHENOMENA.

For the past year he has complained of dizziness and headache, which would begin in the morning, and by the latter part of the afternoon be intense. He is very irritable, and is said to have had distinct visual hallucinations three weeks ago. Memory for recent events, poor; for past events, good; has not had any disturbance of bladder or bowels, nor girdle sensation.

Examination, January 6th, 1897: Walks awkwardly, dragging the tip of left shoe on the floor, due to weakness of left anterior tibial group of

muscles. Slight ataxia in arms and legs when eyes are closed; no ataxia when eyes are open, or of the trunk muscles. Dynamometer: right 72, left 28. Knee jerks, right, increased, and increased by reinforcement; left,



same. Deep reflexes of forearm; right, normal; left, very slightly increased. Biceps: right, normal; left, unable to elicit on account of rupture of its long head. Tendo-achilles: right, absent; left, absent. Ankle, clonus, absent; masseter, absent. Plantar reflexes: right, slight; left, slight. Cremasteric: right, increased; left, increased. Abdominal: right, increased; left the same. Tactile sense (see chart) is lost throughout the

entire left side of the body, excepting an area about four inches long and two inches wide; midway between the knee and ankle, a spot about the size of a silver dollar on the outer side of the leg, below the knee, the entire left ear and left side of penis. Pain sense is lost throughout the left side of the body, excepting where tactile sensibility is present, but is lessened in these spots. Temperature and localization senses lost. Postural and joint senses present. Pressure sense is only recognized when a very heavy weight is used, and then only as a slight touch. Muscular power of left side lessened; right side, good. All sensory phenomena, normal throughout the right side.

Measurement: Forearm, right, $9\frac{1}{4}$; left, 9. Upper arm, right, 9; left, $8\frac{1}{2}$. Difference due to retraction of biceps. Calf, right, $12\frac{3}{4}$; left, $12\frac{1}{2}$. Thigh, 7 inches above knee, right, $16\frac{1}{4}$; left, $16\frac{1}{2}$. Tongue protruded in the median line; no apparent disturbance in the emotional or voluntary movements of the mouth. No contractures of any muscles. Slight consolidation and most rales in both apices. Urine, large deposit of brick-dust sediment, sp. gr. 1026; no albumen nor sugar.

Hearing (watch) not heard on contact in either ear; tuning fork heard best in right ear. Smell, absent on left side, detects odors on right side, but cannot name substance used. Taste: right, present; left, absent. Eyes, arcus senilis, well marked. R. R. V., 30-20; left, 40-20. Pupils equal, and respond to light and accommodation. Muscular movements of eyes good. Fields slightly contracted, probably due to age of patient. Fundi normal. At the time of the examination, patient suffered from partial aphonia.

As to the differential diagnosis, we can exclude all diseases of the peripheral nerves and spinal cord, by the extent of the symptoms, and the involvement of the special senses. The lesions of the brain, which we have to consider, are: First, acute inflammatory affections of the brain and its membranes; second, chronic lesions, as tumors, abscesses and sclerosis; third, sudden lesions, as hemorrhage, thrombosis and embolism. We can exclude the first group of diseases by the rapid onset, the symptoms reaching their height in from two days to a week; the presence of fever and considerable headache. In tumor and abscess, optic neuritis, associated with the characteristic headache, in that it is constant with periods of exacerbations, disturbs sleep, and does not cease when delirium comes on, vomiting and convulsions. In the latter disease we have added, as a rule, rigors and chills, while in both, we have focal symptoms according to the location of the lesion. The absence of nystagmus, jerky inco-ordination on attempts at voluntary movements, and progressive weakness in limbs are sufficient to exclude sclerosis of the brain and cord.

One is not justified in making a diagnosis of embolism, unless endocarditis or suppuration is present in some portion of the body. The onset without the loss of consciousness, age, non-involvement of face or eyes by motor paralysis, condition of the reflexes, absence of rigidity, wasting and contractures, enable us to pass cerebral hemorrhage.

The case under observation resembles more closely that of cerebral thrombosis, but this can be excluded by the absence of premonitory symp-

toms, such as numb and tingling sensations in this case, and, again, the subsequent symptoms are not in accordance with those of true thrombosis. Atheroma of the cerebral vessels usually produces intense giddiness and headache, as is found in this case. Although this patient is aged, I am of the opinion that the last named symptoms are not due to affection of the cerebral vessels, on account of the age when they were first manifested, and the lack of the history of syphilis or alcoholism.

I am unable to find any evidence of thickening of the coats of the radial or temporal arteries.

The convulsive attacks which he has suffered from, may lead one to think that he is subject to idiopathic epilepsy. The mode of onset, the absence of an aura, duration of attack, and the absence of tongue-biting, and micturating during the attack would enable us to come to a conclusion as to the nature of these convulsions.

The following symptoms are of importance in making a diagnosis in the case: Age at which the symptoms began, sudden onset, with gradual loss of muscular power, associated with slight wasting, disturbance in sensory phenomena, aphonia, presence of convulsions, no involvement of the eyes, or contractures, conditions of superficial and deep reflexes.

The motor and sensory symptoms are two of the most prominent and important factors in making a diagnosis in this case. In hysterical motor paralysis, it is the rule not to have the face affected, but to have the special senses involved to a greater extent; also the proximal portion of the limb is paralyzed to the same degree as the distal. Aphonia is one of the classical symptoms of hysteria; the disturbance in speech, if it were organic, would be either a motor or sensory aphasic condition. Hemianesthesia, with spots where tactile sensibility is preserved, with no involvement of pupils or fields of vision, points directly to functional trouble, although it is the rule in functional affections to have crossed amblyopia, associated with hemiplegia and hemianesthesia; whereas, in organic, homonymous hemianopsia will be present.

*The sensory disturbance from a cortical or subcortical lesion, is most marked for muscular and localization sensations, next for tactile, and least for temperature and pain sensations.

In the case under observation, it is seen that the sensory phenomena, which are least affected in organic disease, are completely abolished. The deep reflexes in functional troubles are increased on both sides of the body, while in organic disease they are markedly exaggerated on the paralyzed side. Also, in the former, the superficial reflexes are never lost on the effected side; in the latter they are abolished.

The convulsive attacks do not resemble epilepsy in any particular. Gowers says: "When the initial epileptic fit is severe, its occurrence can usually be ascertained, and tongue-biting alone may be taken as establishing its occurrence."

In a case of organic disease of the nervous system, with a duration as long as that of this case, we would most certainly have marked wasting and contractures of the muscles. After considering the principal points in

* J. T. Eskridge, Colorado State Medical Society Proceedings, 1896, page 409.

the case, we must come to the conclusion that the patient is suffering from hysteria.

The prognosis is good, as was manifested after the patient had been under treatment for a short time.

The treatment consisted of ten grains of potassium iodide three times a day, and the use of hypnotic suggestion. During the first hypnotic treatment, the anesthesia was transferred to the opposite side of the body, and the suggestion was made that sensation would first return in the face, and later in other portions of the affected side; also that motor power would return.

When he awoke he had visual hallucinations, and made violent movements with both sides of the body. On being reprimanded for his actions, he immediately became quiescent, and one hour later demonstrated how he could use his paralyzed hand, making the statement, that the power in the left hand was greater than it had been for years. Sensory phenomena were perfect in the face.

As to the progress of the case, I am unable to say, owing to the fact that the patient did not consult me after sensation and muscular power returned.